Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

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AUTO ACCIDENT FORM

Patient Name _____ Today's Date _____

CLAIM FILING INFORMATION (Responsible party's auto insurance company information)

Insurance Co. _____ Policy Holder's Name _____ Policy # _____

Agent Name _____ Agent Phone# _____ **Claim #** _____

Agent Address _____ City _____ State _____ Zip _____

YOUR AUTO INSURANCE COMPANY INFORMATION

Insurance Co. _____ Policy Holder's Name _____ Policy # _____

Agent Name _____ Agent Phone # _____ **Claim #** _____

Agent Address _____ City _____ State _____ Zip _____

ATTORNEY INFORMATION (If applicable)

Attorney Name _____ Attorney Phone # _____ **File #** _____

Attorney Address _____ City _____ State _____ Zip _____

MECHANISM OF INJURY

Date of Collision _____/_____/_____ Hour of Accident _____ ☐ AM ☐ PM

Please describe how the collision happened _____

_____

Were you wearing a seatbelt? ☐ No ☐ Yes If yes, what type? ☐ Lap Belt ☐ Shoulder Belt ☐ Both

What was your position in the car? ☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger

What type and year of vehicle were you in? _____

Direction of Impact: ☐ Left ☐ Right ☐ Front ☐ Rear ☐ Other _____

What was the approximate speed of your vehicle when the accident occurred? _____ mph ☐ Unknown

What type and year of vehicle struck yours? _____

What was the approximate speed of the vehicle that struck yours when the accident occurred? _____ mph ☐ Unknown

Did you strike another vehicle? ☐ No ☐ Yes Did another vehicle strike your vehicle? ☐ No ☐ Yes

If second collision – Direction of 2nd impact: ☐ Left ☐ Right ☐ Front ☐ Other _____

Did the airbag(s) deploy? ☐ No ☐ Yes

Did you lose consciousness as a result of the accident? ☐ No ☐ Yes

In relation to the back of your head, was your headrest set: ☐ Low ☐ Middle ☐ High

Were you surprised by the impact? ☐ No ☐ Yes If "NO", how did you brace? ☐ With hands ☐ With feet ☐ Both

Where was your head facing at the time of impact? ☐ Straight ahead ☐ Left ☐ Right ☐ Behind ☐ Inclined

Did you feel pain immediately after the accident? ☐ No ☐ Yes If yes, approximately how soon? _____

Area(s) of immediate pain: _____

If you were the "Driver", were your hands on the steering wheel? ☐ Both ☐ Left ☐ Right

Were you leaning forward at the time of impact? ☐ No ☐ Yes

If "YES", check all and specify what part of your body struck what (i.e. head, chest, chin, shoulder, knee, etc.)

☐ Steering Wheel ☐ Windshield ☐ Dashboard ☐ Roof ☐ Left Side Door ☐ Right Side Door ☐ Left Window ☐ Right Window

☐ Other _____

Did your seat break or bend? ☐ No ☐ Yes

Immediately following the accident, how did you feel? (Check all that apply) ☐ Dizzy ☐ Dazed ☐ Weak ☐ Upset ☐ Disoriented

☐ Nervous ☐ Nauseous ☐ Other _____

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MECHANISM OF INJURY continued…

Since the Motor Vehicle Collision, have you experienced any of the following (Check all that apply & explain):

A. Dizziness ☐ No ☐ Yes If yes, what frequency of your awake time? _____
B. Loss of Range of Motion ☐ No ☐ Yes If yes, what body parts? _____
C. Visual Disturbance ☐ No ☐ Yes If yes, please explain _____
D. Anxiety ☐ No ☐ Yes If yes, what frequency of your awake time? _____
E. Depression ☐ No ☐ Yes If yes, what frequency of your awake time? _____
F. Difficulty Sleeping ☐ No ☐ Yes If yes, how often _____

POLICE AND AMBULANCE

Was the accident reported to the police? ☐ No ☐ Yes If yes, please produce report.

Were traffic citations issued? ☐ No ☐ Yes If "YES", to whom? _____

Did you go to the hospital? ☐ No ☐ Yes If "YES", when? _____

If "YES", how did you get there? ☐ Ambulance ☐ Police Car ☐ Private Transportation Were you admitted? ☐ No ☐ Yes

If "YES", how long? _____ Name of Hospital? _____ Attended by Dr. _____

What treatment was given? (Check all that apply) ☐ None ☐ X-rays ☐ Pain Medication ☐ Stitches ☐ Muscle Relaxants ☐ Bandaged

☐ Cervical Collar ☐ Physical Therapy ☐ Instructed Regarding Concussion ☐ Instructed Regarding Sprains & Strains

☐ Instructed to Call an Orthopedist ☐ Instructed to Call a Private Physician ☐ Referred to This Office ☐ Other _____

What other doctor have you seen as a result of this injury? _____

Any symptoms other than above? _____

DUTIES UNDER DURESS SUMMARY

Check the day-to-day living **duties that are difficult or painful** for you to do as a result of your injuries from this motor vehicle collision.

What is your job description? _____

Check all Activities that you have difficulty with at work below:
☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other _____

Check all Activities that you have difficulty with doing School/Studies:
☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other _____

Check all Activities that you have difficulty with doing Domestic Duties:
☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other _____

Check all Activities that you have difficulty with doing Household Duties:
☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other _____

LOSS OF ENJOYMENT SUMMARY

Check all activities as they relate to your lifestyle, work and daily activities that you normally would be enjoying, but are currently **not enjoying** or have had to reduce the time you are capable of experiencing them as a result of this motor vehicle collision.

What is your job description? _____

Check all Activities that you have difficulty with at work:
☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other _____

Check all Activities that you have difficulty with doing School/Studies:
☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other _____

Check all Activities that you have difficulty with doing Domestic Duties:
☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other _____

Check all Activities that you have difficulty with doing Household Duties:
☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other _____

Check and name all Sports Activities that are having difficulty with as a result of your injuries from this motor vehicle collision.
☐ Social _____ ☐ Competitive _____ ☐ Regional _____ ☐ Other _____

My signature below certifies that the above information is true and complete to the best of my knowledge.

_____ _____ _____
Name of Patient (Printed) Signature of Patient Date

_____ _____
(Signature of Legal Representative if patient a minor) Relationship (e.g. Guardian or Parent if patient a minor)